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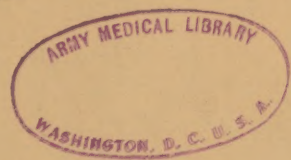
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# CORRELATED SERVICES

An Additional Chapter  
• IN •

WISCONSIN'S CARE FOR  
CLEFT PALATE CHILDREN





# CORRELATED SERVICES

An Additional Chapter in

## Wisconsin's Care For Cleft Palate Children

CHARLOTTE G. WELLS

GRETCHEN A. MUELLER

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Department of Public Instruction

Wisconsin. Bureau for Handicapped Children,

Madison, Wisconsin, January 1946-MD



CONSULTED SERVICES

AN ADDRESS LIST IN

Wisconsin's Care For Child Patients

CHARLES D. WILK

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WISCONSIN'S CARE FOR CHILD PATIENTS

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## FOREWORD

This is the third bulletin which has been written to indicate the essential elements of a rather complete program for children with cleft palates. The first one, "Speech Therapy, a New Chapter" was written at the end of the first year's work. This bulletin is written at the end of the third year and is planned as a supplement to the first one. It is designed to be of interest to workers in this field such as plastic surgeons, orthodontists, speech correctionists, and administrators of like programs.

Children with cleft palates differ as do all other children. They are individuals with a common defect but their needs are not always the same. Some need surgery and time to develop into normal boys and girls; others need surgery, time for development, and speech therapy; while still others may need these, plus considerable orthodontia. For some, the program extends only over a period of two or three years; while for others, a period of twelve to fifteen years is required if the child is to be rehabilitated as effectively as we believe he should be. It should be understood that such a program can be developed only in accordance with the development of the individual child and that it requires a long period of supervision by a speech therapist.

Teamwork with children early enough may prevent the need for formal rehabilitation or its necessity in later years when the individual should be at, or preparing for, his life work. This has been one of the goals in the program so well described by Charlotte Wells and Gretchen Mueller in this pamphlet. The team required for this job (and each has made a splendid contribution) are the public health nurse, the teacher, the physician, the social worker, and the family. We wish to acknowledge the individual professional contribution of Dr. Wayne B. Slaughter, plastic surgeon; Dr. Wade R. Plater, orthodontist; Dr. H. K. Tenney, pediatrician; Dr. Harold M. Coon, superintendent of the Wisconsin Orthopedic Hospital, and Miss Ruth Dickey, chief dietitian. We also wish to acknowledge the contribution of Dr. Robert West, speech pathologist, for his counsel during the three years of the program, and that of Miss Virginia Stephenson, child welfare consultant on the staff of the Bureau for Handicapped Children, for her home placements, home supervision, and home contacts. Teamwork secured the results described and those yet to be attained.

FRANK V. POWELL, *Director*  
*Bureau for Handicapped Children*



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## INTRODUCTION

Cooperation is the cementing factor in dealing with the whole child in a program such as that carried out in the speech training centers for cleft palate children in Wisconsin.<sup>1</sup> Any program designed to be of service to the handicapped child must be broad in scope if it is to aid the child to the fullest extent. In the programs of the speech training centers for cleft palate children, improvement in speech has been a primary goal. But children away from their families, living in boarding homes in a strange city, having new experiences, meeting new people, building new habits in behavior and in adjustment, as well as in speech, need much more than the special speech training they receive.

The child must be referred to the training center. He must be prepared for his trip to the city in which the center is to be held, for a several weeks' stay away from home and for meeting strange boarding parents, teachers, and fellow-pupils. He will need supervision, emergency medical care, transportation, clothing, and recreation, as well as the speech training he is to receive. Many agencies and many services must be ready to help him if he is to gain the greatest possible benefit from his experience and if he is to continue his improvement after the speech training center session has ended.

The purpose of this bulletin is to indicate the multiple services necessary to the successful carrying out of a program designed primarily to improve the speech of the child born with a cleft palate, whose palate has been surgically repaired but whose speech remains defective. The background of such a program, the need for the program, its objectives, and the importance of speech training in the total plan will be briefly summarized in this bulletin. Referral, planning, transportation, boarding home care and recreation, additional diagnostic services, remedial services, provision and maintenance of classroom space, teaching, administration, and follow-up are all part of the program. The correlation of these services will be discussed and illustrated here. No one service is more important than the others, for all must cooperate if the final objective of good speech for the cleft palate child is to be achieved.

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<sup>1</sup> Described in the bulletin "Speech Therapy, a New Chapter in Wisconsin's Care for Handicapped Children", published by the Wisconsin State Department of Public Instruction, 1944.



## HISTORY OF THE PROGRAM

Since 1917, doctors attending the birth of a child born with a cleft lip or cleft palate or both in the state of Wisconsin have been required to report such cases to the State Board of Health. Compliance with this law gives us some facts concerning the number of children who need help both from a surgical point of view and for speech rehabilitation.

In 1931, the Board of Health began to report these congenital deformities to the Bureau for Handicapped Children and since that time this bureau has kept a record of all work done for children so reported. Surgical repair has been accepted as a matter of course and, as soon as a child is reported, help in planning a program is offered to the family physician so that, if necessary, surgery may be planned immediately. Cleft lip operations are usually planned and carried out within ten days of birth. Further surgery follows at the recommendation of the physician.

Since 1943 much more has been added to the program for the cleft palate child. In that year the first speech training center was held and the horizons of the entire program were broadened. The use of the repaired palate for speech rather than surgical repair alone, became the primary factor in rehabilitation. If children could not be given help in the special center for cleft palate children, their teachers and parents were given help in training them in correct speech habits at home. The work of one member of the original training center staff was to contact the parents and teachers of cleft palate children and give whatever help was necessary in this line.

Even with this addition to the services, the program was not complete. In April of 1945 an orthodontist was added on a part-time basis to the staff of the Wisconsin Orthopedic Hospital. In consultation with the plastic surgeon, plans were made to improve the functioning and appearance of the dental arch and the teeth alignment. The improvement of certain speech sounds which depended on this adjustment was also taken into consideration. Of course there were, and are, some cases which could not be helped by operative procedure nor by orthodontia, so consultation with an expert in making and fitting prosthetic devices for the mouth was arranged. About twelve children, selected by the plastic surgeon for the examination, benefited from this consultation service. The orthodontia program is progressing as rapidly as can be hoped for with the limitation of equipment and personnel. About twenty-five children have been



examined and the impressions for study models of their mouths have been made to begin plans for improvement. Sixteen of these children are under treatment at the present time. Until these services are made available to all the children who need them, the program, in spite of its rapid advance, will not be complete.

## INCIDENCE OF CLEFT PALATE IN WISCONSIN

Just how many cleft palate cases there are in the world is not known. It is usually considered that the average for the United States is one in every 1,000, although other figures suggest one in every 2,200. We do know that there are 736 children in the state of Wisconsin born during the last ten years, from January 1, 1935 through December 31, 1944, who have cleft palates and/or cleft lips.

### Number of Cleft Lip and Cleft Palate Cases Known to the Bureau for Handicapped Children from January 1, 1935 Through December 31, 1944

<i>Year</i>	<i>Cleft Lip</i>	<i>Cleft Palate</i>	<i>Both</i>	<i>Total</i>	<i>Deaths</i>
1935 .....	15	29	34	78	1
1936 .....	23	22	31	76	2
1937 .....	28	13	35	76	9
1938 .....	16	19	40	75	16
1939 .....	19	16	41	76	1
1940 .....	10	16	30	56	1
1941 .....	15	17	36	68	4
1942 .....	14	19	42	75	6
1943 .....	17	22	39	78	5
1944 .....	20	22	36	78	7
Totals .....	177	195	364	736	52
1945 (Jan. 1 through Sept. 30)	17	18	29	64	

The distribution of these children in Wisconsin is shown on the map in this bulletin.

The task of providing rehabilitation services for all of Wisconsin's cleft palate children is not insurmountable. There is, at present, a "backlog" of cleft palate children who need attention, but their complete rehabilitation can be part of the same program that will initiate services for the 60 to 80 cleft palate children who will be born each year.

Number of Cleft Lip and Cleft Palate Cases Known to the  
Bureau for Handicapped Children from January  
1, 1935 Through December 31, 1944

(Distribution by Counties)





## OBJECTIVES OF THE PROGRAM

The objectives of any program having to do with a handicapped child must go beyond surgical repair. We must consider the needs of the whole child; his physical, social, psychological, educational, and emotional needs must be cared for.

In the field of health, besides the operative repair needed to make a palate that functions effectively, further surgery may be required to improve appearance, to make the lip more flexible and usable, to straighten the nose, and to assure normal growth of teeth. Hearing should be checked carefully as the hearing of cleft palate children is frequently affected.

The social aspects of the needs of a cleft palate child cannot be over-emphasized. These needs for security, for love and affection, for self-expression, and opportunity are manifested very early. Because a child is away from his family so much through hospitalization, the people working with the child must also know of these social needs and help in securing their fulfillment for the child. All those concerned must work for the welfare of the child as an individual, must recognize his difference from others, must accept him for what he really is, and must recognize his democratic right of self-direction.

Psychologically and emotionally, both the family and the child must make many adjustments. The attitude of the parents must not be one of resentment, nor of overprotectiveness. They must realize the loneliness often brought about by physical difference and give emotional warmth, stability, and guidance at home so that any tendency toward suspicion, bitterness, or asocial attitudes and behavior may be alleviated. A constructive attitude is one in which the parents have insight enough to accept the handicap, to use energies toward compensating for it, and to maintain a natural parent-child relationship.

The child's emotional problems include his recognition of the fact that he is different, his feeling of inferiority because he cannot compete on the same level as other children, and his feeling of rejection from having to be hospitalized so often.

The social, educational, and vocational problems of these children must also be considered as objectives in a program designated to help the whole child. The social component must be considered by the patient's family and associates in helping to organize for him a favorable environment and to provide opportunities and outlets to give a normal adjustment to life. As to educational needs, we must remember that each individual must be treated as an individual, yet must be made to feel that he belongs. Since education of the handi-

capped child is an attempt to equalize educational opportunity, the cleft palate child who needs speech training should get it in his local school, in a special city system that has a speech correctionist, or in the speech training center.

The vocational or economic component of the problem of the cleft palate child must be considered. These children need aid in accepting their physical limitations, be they great or small. They need the aid of someone who knows job specifications, employment trends, resources for training and placement, and vocational information. They must learn to develop to the fullest degree to meet their own problems and to gain satisfaction from life situations.

## THE IMPORTANCE OF SPEECH TRAINING IN THE TOTAL PROGRAM

The work of the plastic surgeon, the orthodontist, the prosthesis maker, and the speech correctionist is judged, in the final analysis, on the basis of the child's speech. Those who hear the child as he recites in class, talks at home, or plays with his friends, form their opinions of the success of the rehabilitation program, not in terms of the surgical end-results, but in terms of the intelligibility and normalcy of the child's speech.

J was four years old. He had been born with a cleft palate and surgery had given him a palate that appeared adequate. However, the plastic surgeon indicated that further surgery would certainly be needed unless the child could learn to use his palate more effectively. A decision about surgery depended on the results of speech training. J responded well to the work of the speech training center, will have speech within normal limits, and will need no further surgery.

D's palate, surgically repaired, failed to function for speech. It remained immobile, but further surgery was thought inadvisable. Speech training taught her to use her palate adequately, to speak clearly.

V, at 14, had poor speech, nasalized many sounds, failed to use his palate for closure of the passage from the mouth to the nasal cavities. At the end of eight weeks' training, he produced all speech sounds correctly, used them clearly in conversational speech, and was so encouraged by his success that he was well able to continue improvement by himself.

These few examples could be multiplied many times to illustrate the importance of speech training in a program for cleft palate children. Surgery almost always gives the cleft palate child the mate-



rials with which to produce adequate speech. The speech correctionist must teach him to use those speech organs to the best advantage. The cleft palate child feels his handicap greatly if he is unable to make himself understood or if his speech is so unpleasant to the listener as to interfere with optimum communication. Such a child is sensitive to the remarks of those thoughtless enough to comment on or imitate his speech. To the cleft palate child, speech training is essential unless he has had surgery early enough to prevent the formation of poor speech habits. As his speech improves, his school work may improve because he can be understood, will be called on to recite, and can take his equal share in classroom conversation. As his speech improves, his personality may improve because he no longer feels different or unwanted or laughed-at. As his speech improves, his social relationships are made easier, because he is not now an "abnormal" or "defective" person, but one who can enter into social events feeling equal to others.

Speech training is the core of the speech training center program. It should be the primary aim of the work. But speech training is easier for children who are well-adjusted, well-nourished, secure, happy in their boarding homes, and motivated by family interest in their progress.

With improvement in speech as the basic aim, as the central point of concern, the speech training centers held in 1943, 1944, and 1945 attempted to bring together many agencies to serve the cleft palate child whose speech was inadequate for his needs. The correlation of these services with the special speech training provided was one of the most interesting phases of the entire speech training center program.

## CORRELATION OF SERVICES

*The referring agencies* used in making plans for our speech training center were innumerable. The records of the Bureau for Handicapped Children and the Wisconsin Orthopedic Hospital were checked and any child between the ages of four and ten whose palate surgery was complete was considered. Letters were sent to the county or city nurse asking an evaluation of the child which included his intelligence, the state of his palate repair, his adjustability in school and possible boarding home situations. In most instances the county or city superintendent of schools and the child's teacher were consulted by the nurse concerning his school adjustment. In cases where there were no nurses, the superintendent did most of the work of explaining the service of the clinic to the parents.

Besides these general ways of referring children there were special instances that always prove the rule of exceptions. G was referred to

the speech training center to see if he could gain palate closure through exercise rather than attempting an operation for elongation of the palate. The parents of A wrote in to inquire if he were eligible for training because the grandparents had heard of the work of the school. Friends of J's mother had written her in California telling about the speech school and she made inquiries concerning enrolling J. The speech correctionist of a city school system, who had visited the speech training center one session, desired a concentrated program for C and requested that she be included in the enrollment. M. J. and her sister L were referred by the university speech clinic after they had had some individual work with student clinicians and it was felt that they would profit by a concentrated program. The state school for dependent children referred two children. The sources of referral were many and varied, but the purpose was accomplished in finding the children who needed the service.

*Planning the program* required much correlation of services. County and city nurses who were familiar with the individual children were able to help very much. They could effectively explain the program to the parents. They answered questions which the parents might have concerning boarding homes, clothing, transportation, and recreation. Several supervising teachers gave their able assistance. Miss G helped to collect clothing and saw that E's mother was able to repair it so that E could have an adequate wardrobe for the summer. The child welfare consultant of the Bureau for Handicapped Children made home calls before making boarding home placements in an attempt to make the best possible placement for each child.

*Transportation* presented many difficulties, both in getting the children to the city where the center was held and in getting the children to and from school every day. Again the nurses, county and city, played a big part in the arrangements. Many children were brought to the city by their parents; others came with friends and relatives. A was driven down by the county sheriff because no other transportation was available. E was put on a train by her mother, met and put on her connecting train at a junction point by the Traveler's Aid, and was assisted in finding the right station by the train conductor.

Within the city the bus drivers were very friendly and soon learned to recognize the children and to help them when help was necessary.

For the first few days of each school term, a "rider" and "walker" system was instituted. High school and university girls were hired to ride the buses or to walk to and from school with groups of children who lived in the same neighborhood. With very young chil-



dren, this system had to be continued all during the session, but many of the older children were soon able to learn the way and could come to and from school without help.

Children had to keep appointments in various buildings at the university. The Girl Scouts made available a group of girls who "convoyed" these children to and from their appointments. This was a tremendous service and one which the scouts assumed for the summer months.

*Boarding home care* played one of the biggest parts in the total picture of the speech training centers. All homes were chosen by the child welfare consultant with the child clearly in mind and certain major points were considered, namely, the part the boarding mother, boarding father, older children, relatives, and other handicapped children had to play. The problem of church affiliation was also considered in placing children in homes.

The children gained much in their boarding home situations. They learned to get along with other people. They learned to adjust to new situations. They were able to fit into a family that was not their own. They learned sleeping, eating, and recreational habits which were not always the same as those to which they had been accustomed at home.

The situation proved to be educational to many. B learned how to embroider since her boarding mother did much hand work. She embroidered a piece to take along home to her own mother. J, C, and L, who stayed at the same boarding home, saw many points of interest in their state Capitol. They made short trips to nearby points of interest such as the Cave of the Mounds. E learned a bit about carpentry work from his boarding father who had a shop in his basement.

Many of the children learned simple home tasks which were required in the boarding home and had not been required in their own homes.

The socialization of many of these handicapped children was extended through contacts with neighbors and friends. Their recreation included swimming (at least six children each year took advantage of the swimming instructions offered in the city), movies (one girl who had never seen a movie before saw two in one day), picnics (which most boarding mothers arranged), trips (to the zoo, the flower gardens, the nearby parks, the historical museum), and general visiting with neighbors and relatives.

There was a great deal of fellowship for these children, who usually feel themselves different from others, because they were able to see others with the same handicap. Also many of the children stayed in the same boarding home. Three four-year-old boys lived together in one home. Three others, aged 11, 13, and 14, lived in

another. Two girls of ten shared a bedroom. Many fine friendships developed and correspondence between many pupils was continued after the close of the summer sessions.

Supervision of the boarding homes was done by the child welfare consultant of the Bureau for Handicapped Children. In addition to her home visits, she kept in touch with the boarding mother by telephone. At the end of the session, the consultant and one of the teachers called on the boarding mothers to express appreciation for the help received, and to get a better picture of what the children's adjustments had been.

Pictures of each child were taken at the boarding home, with the boarding mother if possible. Prints of these pictures were sent to each child and each boarding mother concerned. This seemed to be one of the things which both appreciated very much.

*Diagnostic services* to provide an evaluation of the child's needs, abilities, special problems, and potentialities are essential in any educational program. We need to know what further surgery is needed for the cleft palate child, not only to give him a palate that functions well, but to improve his appearance. We should know whether or not he needs orthodontia, what his mental abilities are, how well he hears, how well he sees. We must guard at all times during the training center session against communicable diseases. We must notice and refer for examination any physical disability. We must be aware of slight behavior difficulties that may indicate illness, strain, homesickness, or mental and social immaturity. We must see the child as a whole at all times, not just as a speech problem.

During each session of the speech training center, the plastic surgeon sees all of the children, dictates a report on the condition of the palate, lip, mouth, and teeth, and recommends further surgery and orthodontia. The services of the plastic surgeon begin with the first operative repair of the cleft lip or palate. They continue, often for many years, until the lip and palate are in maximum condition, both functionally and cosmetically.

The orthodontist works with the plastic surgeon, planning with him the removal of teeth, and the application of bands and braces. In many cases, speech training should begin before orthodontia and continue during the time the teeth are being aligned, removed, or replaced. If orthodontia is to follow speech training, articulatory skills and habits and the discrimination of correct and incorrect sounds will be of value to the child in compensating for changing dental conditions.

Another service made available to all children attending the speech training center is psychometry. The university facilities are called in to provide an evaluation of the educational and mental maturity of each child. The department of education at the University of Wis-



consin provides for mental testing early in the training center session for those children whose group placement for speech work is questioned by the speech therapists. Complete Binet testing is provided for all of the children. Tests for those who seem to be of average learning ability have sometimes been done by students in Binet testing at the university, under the supervision of the instructor. Reciprocal help is thus given by providing subjects for practice testing after all speech training center pupils have been given a first test.

Because hearing is so important to the development and maintenance of good speech, all children at the speech training center are given hearing tests. A further correlation with the university is in effect here, since the audiometry is frequently done by graduate students from the department of speech interested in hearing problems.

Any unusual deviation from normal hearing is immediately referred to the ear-nose-throat clinic at the Wisconsin General Hospital for diagnosis and treatment.

Other diagnostic services are provided according to individual need. T's boarding mother reported a breaking-out on his leg. He was sent to the pediatrician who was "on call" for all speech training center problems and was referred by him to the dermatology clinic of the Wisconsin General Hospital. This clinic, feeling that he needed more constant care than the boarding mother should be asked to provide, arranged for T to be admitted to the children's floor of the Wisconsin General Hospital for a few days for treatment. J swallowed the nickel given her for bus fare. She was taken at once for fluoroscopic examination and later for x-rays. Medication was prescribed by the pediatrician in consultation with the x-ray department. V's voice was observed by the speech therapist to be hoarse and breathy. She was referred to the speech pathologist at the university, who provided laryngoscopic examination, made certain recommendations, and arranged to see the child again at intervals after the close of the speech training center session. C complained that his feet hurt. Arrangements were made for him to be seen in orthopedic clinic as an outpatient. It was observed that M's gait was awkward, that he was tense and moved stiffly. He, too, was referred to the orthopedic clinic at the request of an examining neurologist of the Wisconsin General Hospital staff.

Recommendations for surgery other than plastic work come through the referral of individual problems to the surgery, ear-nose-throat, and eye clinics at the Wisconsin General Hospital. So J's parents will be advised to have surgery for his hernia, G's to arrange for surgical care to correct a drooping eyelid, and other children who have attended the speech training centers have been recommended for surgical service, as it is needed, to correct crossed eyes, or to remove diseased tonsils that may be removed without damag-

ing palate control. (This last operative procedure has been recommended only in consultation with the plastic surgeon.)

Throughout the three sessions of the speech training center, physical inspection has been the first item on the daily program. Such inspection has been made by the teachers, who called the pediatrician to check any apparent deviation from good health. The pediatricians have felt that the teachers were in a position to observe, not only at the more formal morning inspection but throughout the entire day, any changes in behavior pointing to illness. The teachers have been trained to notice a rash on the skin, a change in the child's attitude, a cough, and other symptoms. The diagnosis of the problem and recommendations for care have been made by the physician who is a member of the staff of the Bureau for Handicapped Children as well as of the Wisconsin General Hospital.

Thus it may be seen that the diagnosis: "This child has a repaired cleft palate and needs speech training" is not enough. Many other findings must be made and the results of many tests—physical, mental, neurological—used in determining the best procedures to aid each child.

*Remedial services* must frequently supplement the diagnostic services which, although they are of great value, cannot always meet the immediate needs of the children at the speech training centers. Frequent emergency care is necessary in such cases as colds, playground accidents, earaches, toothaches, and pediculosis. The services of the boarding family's physician, of the eye-ear-nose-throat clinic and the children's ward at the Wisconsin General Hospital, of the dressing cart at the Wisconsin Orthopedic Hospital, and of local dentists and physicians have been needed and obtained.

The plastic surgeon and the orthodontist, members of the staff of the Wisconsin Orthopedic Hospital, will provide further care for those children who need more surgery and orthodontia. Other orthodontists and dentists may be called upon to carry on the work begun earlier, if a child lives in a part of the state too remote from the training center city to make his return to the Wisconsin Orthopedic Hospital for orthodontia practicable.

But when M had a boil on his arm, it was dressed in the Wisconsin Orthopedic clinic by the resident in plastic surgery; when S was discovered to have pediculosis, she was treated by nurses of the children's floor at the Wisconsin Orthopedic Hospital; when the psychometrist questioned L's ability to focus on objects in an intelligence test, her vision was tested by the eye clinic; when B cried because her ear hurt, she was sent to the ear-nose-throat clinic; when G reported a toothache, he was taken to a local dentist for extraction of the tooth; when L developed a fever at the boarding home in the middle of the night, the boarding mother's family physician

was called; when F skinned her knee during a game at recess, a nurse at the Wisconsin Orthopedic Hospital dressed it; when C fell down the stairs at his boarding home and hurt his head, he was placed in the Wisconsin General Hospital at the recommendation of the pediatrician.

None of these services had any direct relation to the child's speech nor to the speech training he was receiving; yet all of these services, and many more, were important to his well-being, his ability to profit by the summer's work, and his parents' peace of mind in sending him away from home to obtain the speech training he needed.

*Maintenance services*, too, have been part of the total program. Pupils attending the speech training centers have been placed in boarding homes in the city of Madison, but have come daily to the Wisconsin General Hospital for classes. The provision and maintenance of these classrooms was the contribution of another of the many correlated agencies working for the good of the children concerned.

The Wisconsin General Hospital is a familiar place to many of the children who attend the speech training centers, for it is there that most of them have had surgery. The classrooms in the Wisconsin Orthopedic Hospital, taken over by the speech training center for its summer program, have been released for the summer by the Wisconsin General Hospital through arrangements made by its superintendent and the Bureau for Handicapped Children. Nurses and secretarial workers at the orthopedic hospital, janitors and cleaning women, dietitians and kitchen workers have made their contributions to the success of the summer program.

*The teaching staff* during the three sessions of the speech training center for cleft palate children, has consisted of teachers who have devoted their full time to the program and of student-teachers for whom part-time work at the training center has been a type of apprenticeship. This use of "apprentice teachers" is another example of the correlation of agencies working to further the work of the training center. Students from the speech clinic at the University of Wisconsin have supplemented the work of the full-time teachers on both a credit and a volunteer basis.

In 1943, only two full-time teachers were engaged for the speech training center. Three other part-time teachers, graduate students in speech correction at the university, volunteered to come to the Wisconsin Orthopedic Hospital to provide help for the regular staff and to obtain experience in special techniques for speech training of cleft palate children. In 1944, the regular staff of three was assisted by several volunteer workers from the university speech clinic. In



1945, both volunteer workers and those using the training center experience for credit aided the staff of three.

A further correlation was possible in 1945 when the director of the speech training center was also appointed supervisor of the university speech clinic. With the aid of a graduate assistant, she planned and supervised both programs and was able to assign student clinicians taking courses in speech correction at the university to part-time work at the training center. These students reported that the teaching experience at the speech training center was of great practical value to them. Other speech correction students found that observation of the training center work aided them in understanding certain phases of speech correction courses at the university. It is hoped that an even more satisfactory form of "apprenticeship" can be worked out to bring together the speech training center, university speech correction students, speech clinicians, and students interested in the university's child development program.

## ADMINISTRATION

No one agency has been responsible for the speech training center programs held during the past three summers. Joint sponsorship of the plan was evident from the first and has been necessary to the continuance of the program. The Federal Children's Bureau, the Bureau for Handicapped Children of the Wisconsin Department of Public Instruction, the University of Wisconsin, the Wisconsin General Hospital, and the Wisconsin Orthopedic Hospital have been concerned in the planning, financing, and administration of the three speech training center sessions held thus far. Each has made its particular contribution. The Federal Children's Bureau provided basic financial aid. The Bureau for Handicapped Children added further financial support, stenographic assistance, teachers' salaries, medical, social, and child welfare consultation service, and administrative supervision. The University of Wisconsin paid some of the salary of the center director in 1943 and assumed responsibility for all of her salary in 1944 and 1945. The Wisconsin General Hospital and the Wisconsin Orthopedic Hospital provided classroom space, maintenance service, and daily lunches for the speech training center pupils at cost.

## FOLLOW-UP PROGRAM

Correlated services make it possible for the child to come to the speech training center, to enjoy and profit by his work there, and to return to his home with improved speech. However, responsibility for his welfare cannot stop when the child leaves the training center classroom. The Bureau for Handicapped Children has engaged a member of the speech training center teaching staff, a former teacher and graduate student in child development at the University of Wisconsin, to travel over the state to secure continued assistance for the speech training center pupil. This worker also visits parents, teachers and supervisors, community welfare workers, city and county nurses, and others in each area to enlist their cooperation in helping the cleft palate child.

She may find that R needs constant reminders to use certain speech skills he has learned at the speech training center. She will discuss and explain the drill work that assures retention of these skills with the child's teacher. She may suggest that a few minutes of each reading or spelling period in the rural school be devoted to speech drills since not only the cleft palate child but all the children may profit by such work.

This travelling teacher may call on the county nurses to enlist their aid in carrying out plans for surgery or orthodontia for some of the children. She may give suggestions on general speech drill to parents. She will certainly provide both parents and teachers with copies of "A Teacher-Parent Guide to Speech Training for Cleft Palate Children", a bulletin issued following the 1944 session of the speech training center.

The plastic surgeon may have recommended that a child return in six months for further surgery. This speech training center staff member who has remained on the staff of the Bureau for Handicapped Children will discuss plans for the return for surgery with the parents, the county nurse, other county or state agencies involved, and the surgeon and hospital. She is constantly correlating many services outside the training center with services directly related to the training center so that the program may be complete.



## CONCLUSION

This bulletin has attempted to provide evidence of the necessarily broad scope of any program designed to aid the handicapped child. It has cited the many agencies, groups, individuals, and organizations that have contributed to the total plan to aid cleft palate children. The file clerk who makes available the record of the birth of a cleft palate child, the bus driver who brings the child to school, the city or county nurse who helps the parents make their plans, the boarding home parents, the cooks who prepare lunches, the teachers, the physicians, surgeons, nurses, dentists, and orthodontists—all these and many others have made the speech training center programs interesting and worthwhile experiments.

The entire rehabilitation of the cleft palate child is a long-time proposition. It begins with the moment of his birth and continues until he has been made a satisfactory member of society. There must be some continuity in the program planned for him. Some person or agency must assume the responsibility to see that surgery is done at the time most favorable; to see that speech correction follows if it is necessary; to see that school adjustment is normal and natural and that the child's successive teachers understand the problems and ambitions of the program planned for the individual; to see that plans for orthodontia are carried out if and when they are necessary and that speech training is again emphasized if it is needed; to see that vocational aid is given if the necessity demands. Since all of this may take 15 or 16 years of a child's life, there must be a continuous thread of planning and continuity woven into the whole pattern to unify it. This appears to be the responsibility of the speech supervisor since she is the constant factor in the never-ending process that makes for a well-finished product.

The program thus far has clarified our thinking and has made us realize the importance of correlated services in giving the best possible "lease on life" to the cleft palate child.

These training centers have shown that short-term intensive speech training can improve the speech of post-operative cleft palate children. However, they have done far more than that. They have demonstrated that no speech program can be only a speech program; that many agencies and numerous individuals must be called in to make such a program complete; that the training centers must have ready access to the social, medical, and recreational services that can add so much to the program; that the service of one agency is just as important as that of any other; and that any such program must consider the child as its center and must focus on him the beams of many lights if we are to drive away the darkness that his handicap has brought and make him a valuable member of society.

